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PREVENTIVE, PROMOTIVE, PRIMARY HEALTH CARE

in DOH Retained Hospitals

The Hospitals as Centers of Wellness Program

Cristina Rosello-Gates

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PREVENTIVE, PROMOTIVE, PRIMARY HEALTH CARE IN DOH RETAINED HOSPITALS
(The Hospitals as Centers of Wellness Program)

Cristina Rosello-Gates

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EXECUTIVE SUMMARY

In a position paper entitled **"Positioning for Performance Towards Health in the Hands of the People"**, the Department of Health (DOH) adopted Primary Health Care (PHC) as a major strategy to pro-actively address endemic problems in the country and promote the health of Filipinos. In response, retained hospitals sought ways of rising to the call. Their efforts evolved into a program known as **Hospitals as Centers of Wellness** or **HCWP.** With its conceptualization and subsequent launching, DOH hospitals began to assume a major role in disease prevention and health promotion hand in hand with their public health counterparts.

A. Baseline Research

A baseline research was conducted in 1993 among eleven (11) retained hospitals to determine the type and extent of ongoing **Preventive, Promotive and Primary Health Care (P/P/PHC)** programs. Findings showed that these hospitals traditionally carried out Maternal and Child Health (MCH) programs as well as programs which addressed specific needs in the localities. Majority of existing preventive care programs, however, dealt with already sick individuals.

In the natural history of diseases, however, "prevention" is carried out on three levels, namely: **Primary Prevention** aimed at reducing the incidence of disease among healthy individuals; **Secondary Prevention** geared at precluding possible complications or shortening the duration of illness among ailing persons; and **Tertiary Prevention** intended to reduce impairment or disability, as well as adjustment problems attendant to the irremediable consequences of disease.

Given this distinction, the programs and activities implemented by hospitals, including pre-discharge instructions to patients and their families, may be classified under the secondary and tertiary prevention levels. The HCWP takes off from the standard activities of clinics and hospitals in the care of the sick. Given time and encouragement, it can ultimately expand toward primary prevention and health promotion as well.

A number of hospitals were found to be capable of innovating within the realm of their own experiences. Noting that, in the course of treatment, the transfer of knowledge and skills to patients and their families gave them the power to take charge of their own health care, support groups began to be organized among, patients, their families, and the hospital staff. These groups carried out patient education programs and made medicines available at lower cost. As a result, a marked decline in hospital admissions was noted. The DOH vision to put health in the hands of the people was, thus, concretized in the hospital setting.

Within a milieu that is predominantly cure-oriented, innovations were confined to a few pockets of dynamism which did not radiate across the entire health network. Still, a handful of hospitals implemented public

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health programs purely on the strength of departmental orders. The baseline survey was able to bring out the fact that among the respondents, only 18.6% understood the DOH vision and its main strategy of Primary Health Care.

Other findings showed that hospital services are distinct and independent from public health services. P/P/PHC belonged to the province of public health. To further aggravate matters, respondents described hospitals as "ailing" organizations needing immediate cure from chronic, debilitating institutional maladies. As a result, the incorporation of P/P/PHC among conventional hospital services was viewed with apprehension. Given these myriad problems, hospitals were ill prepared for such an added burden.

The palpable resistance of hospitals to PHC was not only locally obtaining. A decade earlier, no less than a World Health Organization (WHO) Expert Committee took cognizance of these differences as *"real... and valid... and may result in conflict when brought together..."* (WHO, TRS #744). In recent years, however, the need for collaboration increased with the emergence of lifestyle diseases threatening to afflict the greater population. The concentration of expertise in tertiary care centers propelled hospitals to assume a lead role in battling diseases alongside their public health counterparts.

B. Pilot Testing

The baseline results served as a basis for the following pilot testing activities:

In recent years, the need for collaboration between hospital and public health experts increased with the emergence of lifestyle diseases threatening to afflict the greater population . .

* Creation of an *ad hoc* Committee as a mechanism of collaboration among hospital based specialists and DOH public health program managers;

* Development of a social preparation workshop for hospitals to clarify P/P/PHC concepts and principles in relation to the DOH vision.

The Committee examined the technical support requirements of hospitals for a number of DOH disease prevention programs. The Committee recommended that seminars and orientation sessions be carried out among retained hospitals as a venue for updating hospital physicians on DOH programs and eliciting feedback/suggestions from them. The conduct of a social preparation workshop, on the other hand, pointed to the inclusion of an organizational review module to tackle organizational problems and concerns which may affect the entry and institutionalization of P/P/PHC in hospitals.

C. Program Design

Based on the baseline survey and the pilot testing outcome, the following design was formulated:

1. The Program shall be retitled from **Preventive, Promotive, Primary Health Care in Hospitals** into **Hospitals as Centers of Wellness** to preclude invoking the traditional chasm between hospitals and public health.

2. Adoption of a comprehensive approach in transforming the whole facility into a **Center of Wellness** to counter the resistance of certain hospitals to P/P/PHC.

3. The conceptual framework consists of the Three Ps of Disease Prevention, Health Promotion and Primary Health Care and their respective thrusts of education and technology

transfer in health matters, advocacy for healthy lifestyles, and social equity in health care.

4. The features of a **Center of Wellness** are the Six (6) C's: Comprehensive health care, Competent, Caring and compassionate, Culture-friendly, Community oriented and Clean and Green.

5. The program employs the Priortech Strategy, an acronym for the Primary Health Care Strategy, Organizational Development, and Technical Support.

6. The HCWP commences where the hospitals are - at the level of effecting initial care.

7. The P/P/PHC organization is assisted by committees created for the purpose of assisting program work such as the Technical Service Group (TSG), Hospital Action Group (HAG), the PPP Committee, and the Program Consortia.

In this Monograph, the program features of the HCWP, its subsequent implementation and the recommendations offered for its development are presented. The author perceives that the determination of the true economic costs and benefits of disease prevention and health promotion in hospitals can impact greatly on the efficacy and well-roundedness of health financing schemes propounded by the Health Finance Development Project of the DOH, particularly the National Health Insurance Program which was recently enacted into law.

I.

INTRODUCTION

Socio-economic, political, cultural, financial and environmental factors call for a reinvention of health care systems worldwide. The rise in degenerative disorders, the renewed potency of communicable diseases, the alarming increase in medical costs, interrelatedly, prodded hospitals to deviate from traditional roles and explore new ways of contributing significantly to a more equitable health care system.

In an international survey entitled **Hospitals and Primary Health Care,** notable projects reflect greater hospital and public health collaboration, and the wholehearted participation of people in these innovative programs (Macagba, 1984). Overall, however, efforts were sparse and piecemeal, and hospital reforms hardly made an impact on a grand scale. After redefining hospitals' role in Primary Health Care (PHC) at the first referral level, the World Health Organization (WHO), in recent years, concentrated on meeting the onslaught of lifestyle disorders head on.

In the Philippines, following the devolution of majority of government hospitals to local government units (LGUs), the Department of Health (DOH), in May 1994, launched an innovative program among nationally retained hospitals entitled **Hospitals as Centers of Wellness** (HCWP). It is the culmination of two-years of analysis and planning geared at instituting hospital reforms along the departmental vision of **Health for All Filipinos** and **Health in the Hands of the People.**

The Program is unique for several reasons:

1 It is the first comprehensive program on hospital involvement in disease prevention, health promotion and primary health care implemented on a nationwide scale;

2. Whereas WHO defined hospital role in PHC at the first referral level (district hospitals), the HCWP is aimed at instituting reforms among secondary and tertiary referral levels;

3. The HCWP has adopted PHC among its principles and strategies, it has likewise incorporated WHO's thrust on health promotion;

4. The HCWP institutionalized collaboration between hospital-based specialists and public health experts through the formation of committees;

5. The HCWP incorporated Organization Development (OD) among its approaches to institutionally prepare and trans-

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form once monolithic and disease-oriented medical establishments into **Centers of Wellness.** The development of HCWP consists of two parts :

Stage I: Planning

This phase involved the conduct of a baseline survey among a representative sample of eleven (11) DOH retained hospitals.The survey identified the type and extent of hospital **Preventive/Promotive/Primary Health Care (P/P/PHC)** programs and activities, assessed existing staff atitude and opinion regarding P/P/PHC, and elicited public perception with respect to these programs in hospitals.

Stage II: Implementation

This phase consisted of developing the program design and implementing the program in the 45 retained hospitals. The program framework, strategies, and principles were communicated to the hospitals to serve as basis for their respective implementation plans. Committees were established to facilitate and oversee program implementation. Social preparation, training and orientation workshops were conducted to assess hospital capability for P/P/PHC and ensure the sustainaibility of the program.

A. BASELINE SURVEY

The survey yielded the following findings:

1. Government hospitals, in general, provide P/P/PHC services; however, no monitoring or evaluation process exists to gauge their effectivity;

2. Innovative P/P/PHC, carried out in a number of hospitals to address specific area needs, vary from hospital to hospital. They include the Adopt-a-Barangay and surgical networking projects, and support group formation such as the Asthma Club, Diabetes Club, etc.

3. Only 18.6% of the doctors interviewed clearly understood the concept of P/P/PHC; majority associated PHC with Municipal Health Officers and Barangay Health Workers; hospital involvement in P/P/PHC was viewed as an overlapping function.

4. Hospitals suffer from organizational problems needing immediate attention such as budgetary constraints, bureaucratic red tape, meager resources, dilapidated equipment, overcrowding, understaffing, factionalism, lack of communication, low personnel morale, etc.; this being the case, hospitals may not be institutionally ready for P/P/PHC.

5. The public cannot distinguish P/P/PHC from conventional health services; government hospitals were generally perceived to render inefficient, poor quality services; hospital personnel, on the other hand, were regarded as indifferent to the plight of patients.

Based on these results, consultative meetings were held with top DOH officials, regional field health directors, hospital directors, public health program managers, and service directors for the purpose of developing P/P/PHC in hospitals. The outcomes are cited below:

A.1 Absence of M & E in Ongoing P/P/PHC

From among the on-going P/P/PHC activities in hospitals, the survey showed that the following "high priority" programs did not have a built-in mechanism for monitoring and evaluation (M&E). These include internationally-funded projects and those which address globally-alarming health problems:

Control of Diarrheal Disease (CDD)
Under 5 Clinic
Control of Acute Respi ratory Infections (CARI)
Family Planning
Pulmonary Tuberculosis Control (PTB)
Diabetes Control
Sexually Transmitted Diseases/HIV
Health Education

As an initial step to develop an M & E process, an *ad hoc* Committee composed of public health managers on one hand, and hospital based physicians, on the other, draw up program implementation plans. Trainings were conceived to update hospital personnel on these programs.

In subsequent consultative meetings, DOH officials found the "high priority" list limited in scope. Inclined to give hospitals more room for creativity, the officials expanded coverage to include the following programs which will be implemented in phases.

Phase 1: Integration of the programs listed below under the P/P/PHC program umbrella:

- Mother and Baby-Friendly Hospital Initiative
- Anti-Smoking
- Family Planning
- Control of Diarrheal Disease (CDD)
- Control of Acute Respiratory Infections (CARI)
- Maternal Care and Under 5 Clinic
- Blindness Prevention
- AIDS Prevention, Education and Care

Phase 2: Depending on varying needs in localities, implementation of one or more programs from among the following DOH national priorities:

- Preventive Cardiology
- Preventive Nephrology
- Cancer Prevention
- Diabetes Control
- Pulmonary Tuberculosis Control
- Trauma Management and Accident Prevention
- Poisoning Prevention and Management

Phase 3: Development of innovative programs to widen the reach of the hospitals, improve the quality of services, forge collaborative linkages with other sectors and with communities, etc.

A.2 Innovative P/P/PHC Programs in Retained Hospitals

Ongoing innovative programs were reviewed next for possible replication in other hospitals. Among the benefits noted by the survey were: institutional savings of the hospitals, savings of patients and their families, reduction of medical complications, etc. Apart from quantifiable benefits, a growing number of related investigations suggested that the process of participation, in itself, promoted the health of participants, gave better results, and sustained programs in the long haul (Schwab, et. al., 1993)). The related concept of self-efficacy, defined as the extent to which people have control and responsibility over their lives, was linked to health and well being (Lefebvre, 1988; Bandura, 1987; O'Leary, 1985; Martin, 1983).

Among notable programs, the formation of disease-based support groups proved beneficial to patients and hospitals. In a district hospital, for instance, admission for diabetes plummeted to 3%, three years after its Diabetes Club was organized. In taking over the hospital's Diabetes Education Program, the support group inadvertently relieved the hospital of its perennial problem of the lack of manpower. Diabetics also benefitted from medicines which the Club made available to them at reduced prices. Of late, membership is no longer limited to diabetics. Interested community residents have also joined the Club, including those from neighboring towns. In a similar development, a specialty hospital reported a decline in admission for asthma, barely three months after the launching of its Asthma Club.

The above examples show that innovations carried out within hospital premises may take the form of educating patients and their families, organizing support groups, and developing lay health educators. While support groups have proven their competence in managing hospital patient education programs, their active participation in other activities such as advocacy, multisectoral liaison work, disease surveillance, and monitoring of hospital programs may be explored in the future.

Other innovations involved outreach programs such as the following:

- **Surgical Networking**

A regional hospital in the south brought its surgical services to far-flung areas by networking with local government units and private medical practitioners in the localities. Economic benefits were realized.

One trip resulted in as many as ninety (90)operations of which 30 were minor, 30 medium, and 30 major. Ordinarily, the cost of such a trip could fund only 30 medium operations inside the hospital. On the part of beneficiaries, savings were realized in food and transportation expenses; likewise, they no longer experienced the loss of income usually associated with hospital confinement.

o **Adopt-a-Barangay**

A regional hospital "adopted" a barangay and trained health advocates in every home. The assistance of a civic organization was sought in community organizing. Two years later, the community was well onwards into a soap-making project which enabled them to install a public well and toilets. The hospital agreed to serve as market for the soap products. This is illustrative of how a hospital, by mobilizing an NGO, can successfully employ a community development approach anchored on people participation and self reliance.

o **Barangay Health Workers Training**

A medical center in Metro Manila began holding Barangay Health Workers Classes in a nearby municipality in 1981. Fourteen years later, the Municipal Health Office reported a lower incidence of disease compared to nearby towns. Inspired by the outcome. the hospital linked up with the same MHOs in early 1994 to conduct a training for *hilots* (informal midwives) as a means of skills upgrading to identify high risk pregnancies for proper referral.

The above examples confirmed the findings of an international survey entitled **Primary Health Care and Hospitals** which reported that "...hospitals which reach outside the confines of their walls into the communities appear overall to serve most effectively...there is hard evidence that the general health status of the community is affected positively and increasingly... " (Macagba, 1984)

A.3 The Dichotomy Between P/P/PHC and Public Health

The survey likewise showed that majority of the respondents did not clearly understand the meaning of PHC, the socio-economic context from which it sprung, and its multisectoral approach as aptly captured by the global vision of **Health for All 2000** and the DOH vision of **Health in the Hands of the People.** A study of the responses indicated the following:

o Hospitals associate P/P/PHC with Municipal Health Officers and Barangay Health Workers;

o P/P/PHC is generally perceived to fall within the domain of public health ;

o Hospital involvement in P/P/PHC overlaps with public health functions, and results in waste of time, resources, and specialty training. An extreme position refers to it as "public health intrusion into the hospital arena" which redound to a decrease in hospital clientele and potential income.

It is interesting to note that a decade earlier, the work of a WHO committee seeking to identify the role of hospitals in PHC was intermittently brought to a halt by frequent incursions into the supposed difference between hospitals and public health. In its final report in 1987, the Committee recognized that "...these differences are real and in many respects valid...and may result in conflict when they are brought together. However, health professionals both within and outside hospitals can and should find common ground in a comprehensive view of PHC, despite their differences in tradition and orientation (WHO, TRS #744, 1987).

On the other hand, the minority who seemed knowledgeable in Primary Health Care may be grouped into two clusters, namely :

Cluster 1: Innovators

These doctors, despite or because of their specialty training, sought alternative ways to serve their patients better and, in the process, unintentionally

strayed into public health territory. A number of these physicians pro-actively decided to innovate out of sheer frustration with bureucratic constraints and power struggles. Innovators related their experiences to PHC goals in the face of diminishing resources and emerging diseases, eventually recognizing the valuable contribution hospitals can extend to health promotion and disease prevention.

Cluster 2: Survivors

A number of respondents admitted having directly quoted from advanced copies of a DOH strategy paper for Philippines 2000 entitled **Positioning for Performance towards Health in the Hands of the People.** These doctors revealed that the length of their service in government equipped them with the skills to survive changes in administration and cope with the accompanying shift in departmental policies and priorities. Since the present DOH leadership is generally viewed as leaning towards public health, a cursory knowledge of PHC is thus considered a tool for survival.

A.4 Organizational Problems: Impediments to P/P/PHC

In view of long standing organizational concerns, the survey also found that hospitals were not ready to engage in P/P/PHC. Rather, they preferred attending to pressing organizational and administrative problems which hampered hospital operations and management. According to a number of these doctors, the introduction of another DOH program such as P/P/PHC may further deplete resources/logistics already perceived to be inadequate or misappropriated, thus, aggravating the deplorable condition of hospitals.

Dissatisfaction in the following work areas were noted:

o Communication - lack of venue/ opportunity for sharing ideas, ventilating a and clarifying issues, or simply being heard.

o Personnel Welfare - employees reported feelings of being "burnt-out", overworked and underpaid; moreover, they were themselves sickly, low in morale, and lacking in opportunities for growth and development.

o Management Style - lacked transparency, highly centralized decision-making, favoritism, inconsistent application of policies, etc.

A.5 Hospitals' Public Image

The negative image of government hospitals may be gleaned from complaints aired by watchers and the general public. Cited were unnecessary deaths due to delayed medical intervention, long waiting hours at the outpatient department, lack of emergency drugs, irritability and callousness of hospital personnel to the plight of poor patients, etc. On the other hand, prompt attention was given to patients personally known to officials in the hospital and other politically influential persons. Despite these grievances, interviewees were quick to point out that destitution and having "nowhere else to go" prodded them to seek treatment in government hospitals anyway.

The baseline report aptly described this double bind: "It is pathetic, however, that despite the very valid complaints, the poor still regarded the hospitals with gratitude; the delivery of free services absolved any and all inadequacies... To those without, the little relief bestowed is worth all the difficulties and hardships encountered to obtain that relief. So little is asked. Unfortunately, in a number of hospitals, very little is in fact given." (Gates, 1993, emphasis provided) Given the results of the baseline survey, a pilot test of ongoing DOH programs and a Values Clarification Workshop were then conducted.

B. PILOT TESTING

Pilot testing involved bringing together public health program managers and hospital specialists to identify the initial

list of "high priority" DOH programs. The *ad hoc* Committee conducted seminars in a regional hospital and a medical center in Metro Manila.

B.1 Public Health Seminars

The following seminars on various DOH public health programs were then conducted:

1. Diabetes Control in coordination with the Institute of Studies on Diabetes Foundation
2. Update on the Control of Diarrheal Disease
3. Seminar on the National Pulmonary Tuberculosis Control Program
4. Orientation on HIV/AIDS

The encounter enabled the *ad hoc* Committee and the participants to view health from perspectives removed from their own. The experience paved the way for finding a common ground for collaboration. The seminar surfaced the need to create a committee which shall serve as venue for such a collaboration and provide technical program support to the implementation of DOH programs in hospitals on a sustained basis.

B.2 Values Clarification Workshop

A social preparation workshop was pilot-tested in the regional hospital to ensure a common understanding of the DOH vision, mission, and the concepts of P/P/PHC prior to the crafting of an implementation plan.

Based on the baseline survey results, the Values Clarification Workshop consisted of four (4) modules, namely:

1. Self-awareness;
2. DOH vision, mission, and goals;
3. P/P/PHC; and
4. Action Planning

The self-awareness module designed to identify individual contribution to DOH goals elicited feedback beyond original expectation. The discussion revolved around factors affecting performance and job satisfaction. The outcome validated the findings of the baseline survey, which underscored the need to address organizational problems which stifled personnel growth and development and hindered the effective provision of quality medical care. The feedback brought to the fore a basic PHC tenet: "Start where the people are."

Thus, for any innovation to succeed in hospitals, a consideration of personnel needs is a fundamental activity. The personnel, after all, are the "indigenous leaders" of the hospital "community." As prime movers, they assume the task of mobilizing patients, their families, and the public to become partners and advocates for health. Hence, personnel commitment to the DOH vision is the key to program sustainability in the long run.

In view of the findings, the inclusion of an organizational review module was considered crucial in opening communication channels and breeding mutual trust, teamwork, and a clear understanding of program goals needed in the smooth implementation of HCWP. The module can serve as a diagnostic tool in identifying areas for improvement and assessing hospitals' overall capability to carry out the program.

The organizational diagnosis is part of a comprehensive process seeking to fortify hospitals' ability to cope with change. In management parlance, this process is referred to as Organization Development (OD) Apropos to P/P/PHC, a hospital OD intervention can transform the predominant hospital "culture" from being "cure or sickness-oriented" to one that promotes health and growth. Furthermore, since a medical institution's credibility is determined to a great extent by its competence to render conventional services, OD activities foster the pursuit of excellence among hospital personnel. Indeed, it is only when a hospital strives for excellence that it can easily transform itself into a **Center of Wellness.**

II.

PROGRAM DESIGN

In order to preclude invoking the traditional rivalry between public health and hospital services and the confusion it spawns, the technically sounding **Preventive, Promotive and Primary Health Care Program in Hospitals** shall be replaced by a catchy, generally appealing title - **Hospitals as Centers of Wellness Program* (HCWP).** The positive tone of the term "wellness" which connotes health, comfort, pleasure, ease, and life offsets the negative association of the word "hospital" with illness, discomfort, pain, disease and death.

A. CONCEPTUAL FRAMEWORK: THE 3 P's

As a DOH program, **Hospitals as Centers of Wellness** aims to bring hospitals to the forefront of a broad coalition for **Health for all Filipinos** and **Health in the Hands of the People** by year 2000. In line with the vision, **Hospitals as Centers of Wellness** is predicated upon the following pro-people and proactive principles of Primary Health Care, Promotion of Health, Prevention of Diseases.

A.1 Primary Health Care (PHC)

PHC is viewed in several ways: as a philosophy based on the principles of social equity, self reliance, and community development; as a range of programs determined by the patterns of health and disease of people in a particular area; as a level of health care supported by a referral system; and as a strategy for reorienting the health system in order to provide whole populations with essential care and encourage people participation as well as multisectoral collaboration (WHO TRS : #744, 1987).

A thorough understanding of PHC, however, requires a consideration of the historical context from which it evolved. Primary Health Care was formulated in 1978 (Alma Ata, Russia) as a fervid response to the crisis confronting health systems worldwide characterized by escalating costs of medical care, uncontrollable spread of infectious diseases and massive poverty

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* *"Center of Wellness": Its word associations were culled from a random sample of 30 respondents ; a focused group discussion (FGD) was carried out to determine the "market appeal" of the identified titles : "Healthy Hospitals," "Hospitals as Centers of Wellness," "Ospital Pinoy Style : Sentro ng Kalusugan." A panel of experts consisting of two psychologists and one media representative chose the final title.*

which rendered health services inaccessible to the poor and the disadvantaged. The "medical establishment," in particular, came under fire for its insensitivity to the needs of the poor, its overspecialization on exotic diseases plaguing mostly the elite, the concentration of medical resources in urban areas, and its alliance with drug companies." In the course of time, these establishments came to be viewed as a "threat" to health - their "iatrogenic" (doctor-induced) effects, e.g. nosocomial infections, spawning illness instead of cure.

The crisis in health care was regarded by adherents of PHC as a consequence of the blatantly unjust economic, political, and cultural systems which served the vested interests of a few and trampled upon the rights of majority of the people. The *zeitgeist* of the times was one of radical fervor - a restive pursuit for social justice and equity was felt far and wide.

The need for social reforms prompted the search for alternative systems. Communist China provided a concrete example of an innovative system of health delivery: its use of the voluntary services of Village Health Workers (barefoot "doctors"), its reliance upon indigenous resources as it veered away from expensive, sophisticated technology, its having organized masses into self reliant communes ensured that the people's basic needs, health among them, are met. The Chinese experience served as an inspiration and basis for those who advocated for social reforms. In retrospect, therefore, the lessons from China and the radicalism of the 60's served as the fertile ground from which PHC emerged.

A.2 Health Promotion

The changing epidemiological landscape muddled the social equity issue advanced hereon by PHC. The increasing prevalence of lifestyle diseases, which previously afflicted only the affluent but now threatens the greater population, catapulted Health Promotion to the fore of the campaign for healthy lifestyles. Previously regarded as an integral part of the PHC strategy, in recent years, Health Promotion has evolved into a distinct approach primarily aimed at containing the onslaught of degenerative diseases. With this development, a distinction between Primary Health Care and Health Promotion is in order.

PHC championed the cause of the poor. Anchored on the principle of social equity or "health as a basic human right", it called for a universal coverage of essential health services, i.e. health services should be made "available, accessible, adequate, and acceptable" to the people. In the overall scheme of things, hospitals played a crucial role in a referral system involving different levels of health care. Inequities in health care are rooted in societal systems. Since PHC scans the economic, political, and cultural milieu to determine necessary reforms and advance the health of the masses, it may come in conflict with the interest of the ruling class.

In contrast, health promotion is geared at "inducing behavioral changes in individuals and structural changes within society, the environment, and the health systems." It relies heavily upon the academe where social learning principles, behavior modification theories and strategies abound. While it seeks social support through people empowerment, Health Promotion also values support from policy-makers and legislators. It enjoins hospitals - where the concentration of expertise and resources lies - to assume a dynamic lead role in the advocacy for healthy lifestyles.

A.3 Disease Prevention

While epidemiology as an area of study has contributed to a comprehensive understanding of the causes and cure of various diseases, medical science has fragmented health care into disease prevention, on one hand, and cure/rehabilitative care, on the other. Disease prevention has become the major concern of public health while cure and rehabilitation preoccupy hospitals.

The **Hospitals as Centers of Wellness Program** aims to adopt the concepts of disease and health as a continuum. Thus, in

the natural history of a disease, prevention covers specific protection and extends to primary prevention, where health measures are aimed at reducing the incidence of a disease and other departures from health. Secondary prevention, on the other hand, includes early diagnosis and prompt intervention aimed at shortening the duration of a disease or precluding possible complications. Tertiary prevention measures are intended to reduce impairment and disability, and to enhance the patient's adjustment to irremediable consequences. In effecting a cure, physicians shall employ a comprehensive view in empowering patients and their families with the necessary knowledge, skills, attitudes and values, to ensure full recovery or maintain the health of a chronically ill patient.

In delineating disease prevention from health promotion, it must be underscored that the difference between the two concepts is only one of focus, rather than overall perspective. Prevention is a disease-related concept and subsumes early diagnosis and treatment relative to a specific symptom or ailment. Promotion, on the other hand, is a health-related concept and excludes all clinical activities such as diagnosis, treatment, laboratory examination, and so forth. Its major goal is to foster the adoption of health lifestyles.

Disease prevention activities in hospitals entail the establishment of vertical programs which address specific illnesses endemic in a given locality. Each program employs health education in the dissemination of information to patients and their families regarding the causes, cure, and prevention of particular diseases.

To build further on the conceptual framework of the HCWP, the qualities that constitute a **Center of Wellness** were subsequently defined.

B. FEATURES OF A WELLNESS CENTER: THE SIX C's

In line with the HCWP vision to transform hospitals into **Centers of Wellness**, the following features shall be achieved by the target hospitals:

B.1 Comprehensive Health Care

In a **Center of Wellness**, one can expect to receive a range of medical services that is comprehensive. Since the concentration of health resources and expertise resides in tertiary care centers, hospitals are in a better position to deliver a comprehensive set of health services. In preventing people from getting sick, hospitals contribute to the efficient utilization of resources and the cost containment of otherwise expensive medical care which only a few can afford.

B.2 Competent Service Delivery

A **Center of Wellness** delivers competent health services. A hospital's credibility in health promotion and disease prevention can only be established when its basic services are competently delivered, when the hospital facility is well managed, and its organization exhibits "readiness" for innovation. A hospital which strives for excellence can benefit most from P/P/PHC which sustains health among people, and leaves the hospital to care only for those in need of tertiary services.

B.3 Caring, Compassionate, Communicating

A **Center of Wellness** is also defined as a people-friendly health facility which incorporates psychosocial and environmental measures among its treatment approaches in order to minimize the discomfort and anxiety of patients and their families. In so doing, it hastens the healing process. Counseling, occupational therapy, physical fitness, relaxation sessions, and similar activities may be carried out in hospitals. Thus, treatment is holistic - integrating psycho-social and spiritual aspects as well.

Other measures include physical arrangement and a flow of activities designed to ensure ease and safety of patients, the installation of appropriate

signages in strategic areas, a data bank and a readily available information system on wide ranging topics from hospital policies to home remedies for common diseases, and other relevant matters. A feedback mechanism may be helpful in drawing out suggestions for improvement. Since the lack of financial resources is a source of anxiety among patients, hospitals may explore the provision of income generating opportunities for ambulatory patients or watchers within its premises or other agencies.

The setting up of programs which aim to enhance personnel well being ("care to the caregivers") is meant to transform employees who are generally perceived as demoralized, indifferent and "burnt out" into caring and compassionate hospital staff.

B.4 Culture-friendly

Another outstanding quality of a **Center of Wellness** is its sensitivity to the culture of its locale. Optimal people cooperation and involvement in the treatment process or in hospital programs may be evoked when services are delivered within the context of the local culture. When the policies, systems and procedures of a health facility are culture-sensitive, people's interest and participation in its programs and activities have a greater chance of being sustained in the long run. The presence of watchers in Filipino hospitals, for instance, may be turned into an advantage when they are mobilized to help in the maintenance of cleanliness in the wards, trained to properly care for the patient, and tapped as health advocates when they return home.

B.5 Community-oriented

A **Center of Wellness** has the capability to go beyond its confines and to reach out to the community it serves. To ensure its continued relevance to community life, a hospital shall continually monitor community needs, actively participate in multi-sectoral collaboration with organizations, volunteers, and communities, and establish hospital-based organizations to assist in liaison work, disease surveillance, public relations (PR) activities, follow up of discharged patients, and health advocacy programs. A **Center of Wellness** shall pro-actively anticipate the seasonality of diseases or determine the impact of socio-economic and other developmental activities upon the health of a population.

B.6 Clean and Green

With the established link between health and the environment, hospitals shall contribute to environmental efforts geared at sustainable development, thus meeting the needs of the present generation without jeopardizing the needs of future generations. Thus, hospitals can convert idle hospital grounds into productive areas such as orchards, vegetable herbal gardens, nurseries, properly dispose waste, and include personal hygiene and environmental awareness among its health education programs.

After designing the conceptual framework that serves as the foundation of the program and the definition of a wellness center, do-able strategies were put into place.

C. PRIORTECH: Strategies to Transform Hospitals into Centers of Wellness

A tripartite approach is adopted to convert retained hospitals into **Centers of Wellness.** To be known simply as the PRIORTECH strategy, the acronym stands for Primary Health Care, Organization Development, and Technical Support. Since PHC and organization development (OD) focus on people empowerment (the former in reference to patients, and the latter, in reference to personnel), the strategy signifies that human resource development is of prime importance to the HCWP and shall, therefore, be pursued hand in hand with technical development. Foremost among these strategies is, of course, PHC.

C.1 Primary Health Care Strategy

The strategy involves the transformation of the whole facility into a **Center of Wellness.** It starts "where the hospitals are," builds upon ongoing P/P/PHC programs and activities, and proceeds in phases to the introduction of other priority programs. Anchored upon the principles of people participation, self reliance, and institution building, community organization strategies usually employed in community based PHC programs shall be adopted in hospitals to be known as hospital-based organizing, with the following modifications :

1. The hospital shall be viewed as a community composed of personnel, patients, and their families;

2. Support groups shall be organized among personnel, patients, their families, and other volunteers;

3. Hospitals shall be given a free hand in delivering better service to their constituents;

4. Outreach programs such as the Adopt-a-Barangay, and the barangay health workers training shall be at the discretion of individual hospitals depending upon the factors of time, manpower, hospital resources, endemic health problems, presence of volunteer NGOs, etc.

5. Networking with other government and non-government organizations, local government units, civic organizations etc.

Where applicable, retained hospitals shall adopt a "good neighbor" policy towards adjacent depressed communities and shall establish mutually beneficial relationships with them.

C.2 Organization Development

To ensure that retained hospitals will be capable of innovations and changes similar to the ones initially conceived, organization developent shall be adopted another sstrategy within the hospital setting :

1. A hospital vision shall be drawn up in line with the DOH visions and the conceptual framework of HCWP;

2. Hospital personnel shall be encouraged to identify individual and collective contribution to the wellness program;

3. In creating a climate conducive to healing, cultural beliefs and practices, psychosocial and environmental aspects of medicine shall be taken into consideration in the introduction of reforms in hospital operation and management;

4. Hospital personnel should be given the opportunity to assess their organization, validate their views as a group, and explore possible solutions and courses of action;

5. Readiness for innovation shall be determined by clear goals, teamwork, mutual trust, problemmatic analysis, appropriate leadership styles, decision making, creativity, and values formation.

C.3 Technical Support

The management of emerging disease patterns requires collaboration between public health experts and hospital-based physicians. Venues for collaboration shall be set up where a joint levelling of treatment approaches is made possible. The exchange of ideas and experiences is expected to enrich the expertise of both hospital specialists and public health experts.

In providing technical support to the P/P/PHC activities of retained hospitals, the various service units and national program offices of health department offer assistance along their respective areas of concern and expertise. The DOH central offices concerned are listed in Chart I on the succeeding page, along with the respective types of technical assistance that are being extended to P/P/PHC.

Chart I
DOH Central Office Assistance to P/P/PHC

Office of Health Facilities, Standards and Regulations (OHFSR)
* Policy formulation/legislation in support of HCWP

Hospital Operations and Management Service (HOMS)
* Performance review
* Management audit for reforms
* Institution of quality assurance programs
* Logisitical support

Bureau of Licensing and Regulations (BLR)
* Policy guidelines incorporating wellness parameters as part of the criteria for licensing

Health Mapower Development & Training Services (HMDTS)
* Human resource development programs
* Organizational development workshops

Internal Planning Services (IPS)
* Provision of technical supervision in the preparation of tactical and medium-term strategic planning

Office of Public Health Services (OPHS)
* Development of training modules/activities
* Provision of technical assistance in the development of hospital-based public health programs
* Assistance in the monitoring and evaluation of the HCWP program

Public Information and Health Education Service (PIHES)
* Assist in developing IEC campaign programs and materials
* Provide technical assistance to Health Education and Promotion Officers or their designates in hospitals

Other DOH support services
* Assist HCWP along their respective lines of concern

Regional Field Offices
* Assist in networking
* Provision of logistical and technical support

D. ORGANIZATIONAL STRUCTURE

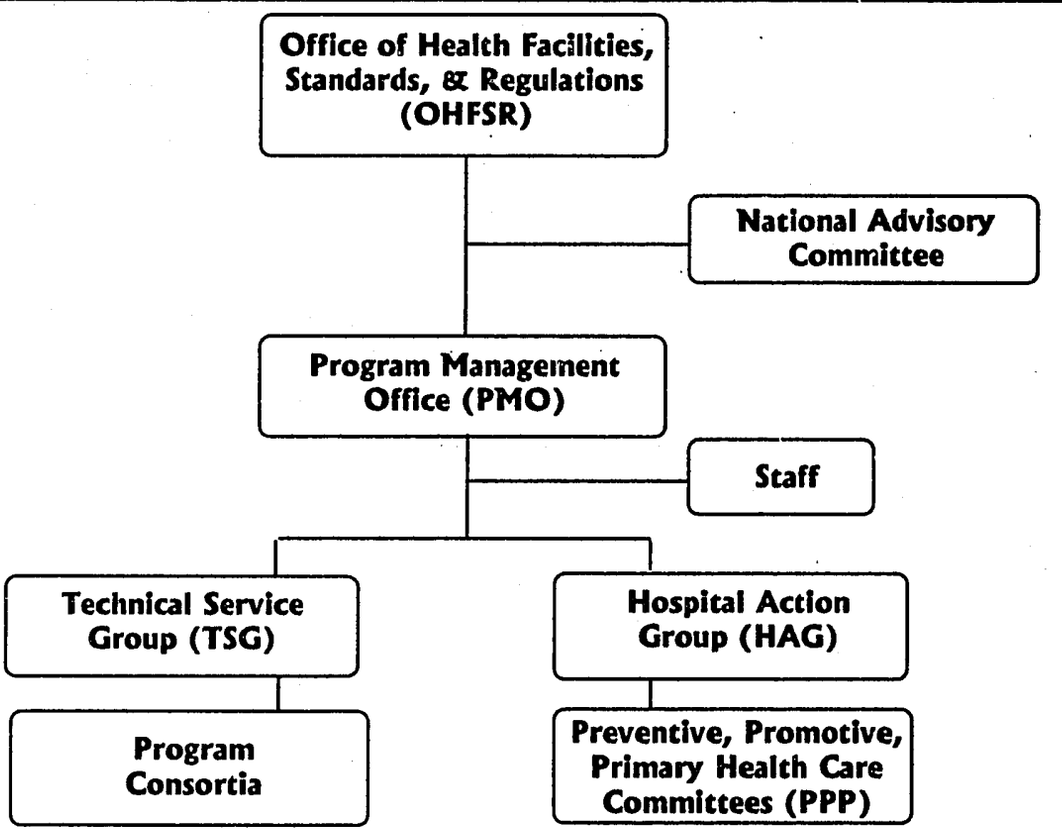
With the mapping out of the institutional strategies came the visualization of the program structure. The HCWP organizational structure (see Chart 2, Page 21) closely follows the program framework. The program shall be housed under the Office of Health Facilities, Standards, and Regulations (OHFSR) of the Department of Health tasked to oversee the country's hospital system. The OHFSR is assisted by an advisory committee in setting directions for the HCWP. Directly under the OHFSR is a committee that assumes day-to-day operations. another committee composed of managers of public health programs and hospital-based specialists provides technical support to the hospital-based P/P/PHC programs and activities.

The Hospital Action Group (HAG), a network of hospital directors, serves as venue for sharing and resource mobilization. The formation of a Preventive/Promotive/Primary Health Care or PPP Committee is intended to ensure that all service units and offices and programs of a hospital are represented. The Program Consortia, made up of the different program coordinators from different hospitals, also functions as a national network specifically for the control of prevalent diseases in the country.

D.1 National Advisory Committee

The National Advisory Committee is the program's governing council and top-level decision-making body. It sets policies to reorient hospitals on the value of promotive, preventive and primary health care, activates groups and systems for program implementation. It initiates and spearheads the department's efforts to replicate, through legislation, the successes of the program by transforming all hospi-

Chart 2
Hospitals As Centers of Wellness
ORGANIZATIONAL STRUCTURE



tals in the country into Centers of Wellness.

D.2 Program Management Office (PMO)

The Program Management Office (PMO) is the overall implementing body in charge of the day-to-day operations of the program. It coordinates the activities of the various committees at the DOH central and regional offices and the hospitals. As such, it is responsible for furnishing the National Advisory Committee with vital information and feedback derived from the line committees under its control and supervision.

D.3 Hospital Action Group

The Hospital Action Group (HAG) is one of the line committees directly under the PMO is responsible for ensuring institutional and administrative support for program implementation among retained hospitals. In particular, it oversees and evaluates health promotion initiatives using the six C's as parameters of the Centers of Wellness. It also serves as the social mobilization arm of national advocacy programs such as the Think Health, HealthLink, and other priority programs of the DOH.

D.4 Technical Service Group

The Technical Service Group (TSG), another line committee of the PMO coordinates all P/P/PHC programs and pro-

vides training and technical expertise for the effective implementation of disease prevention and other vertical programs of the DOH. The TSG is responsible for the development of operating manuals and for regularly monitoring and evaluating specific programs. It shall organize program consortia among hospitals and convene them annually.

D.5 Program Based Consortium

Each consortium is made up of program coordinators from participating hospitals which commonly share prevalent health problems, and which have established or are about to set up projects addressing these problems. Each consortium shall mobilize professional/specialty societies, hospital based support groups, nongovernment organizations, and other volunteers for the establishment of a national network for the control/prevention of a specific disease/disorder and for the holding of annual conventions and similar activities.

D.6 PPP Committees

Each hospital shall organize a PPP Committee to oversee all programs and activities being undertaken. The PPP Committee provides the necessary information and feedback to the HAG on matters related to program implementation. The PPP Committee is not only the individual hospital's direct link to the central committees but is also the program's link to agencies, organizations, and communities outside the DOH structure. It assists HAG in social mobilization projects and serves as the central coordinating committee of the different private and devolved hospitals in their respective localities.

III.

PROGRAM IMPLEMENTATION

The policy considerations, guidelines, strategies, and organizational set up are embodied in three (3) DOH department orders, specifically Department Order No. 391, series of 1993 dated 01 December 1993, Department Circular No. 195, s.1993 dated 01 December 1993, and D.O. No.67-A, s. 1994 dated 14 February 1994. They provided the backbone for the creation of a nationwide organization to implement, monitor and evaluate the program.

A. PROGRAM MANAGEMENT OFFICE (PMO)

Chart 3
PROGRAM MANAGEMENT OFFICE

Postion	Designate	Function
Program Manager	Dr. Ruben Flores	Overall operations of the HCWP
Deputy Program Managers	Dr. Victor de la Cruz Dr. Lydia San Pedro	Organizes HAG Organizes TSG
Technical Staff	Ms. Leticia Espinosa	Technical Support

The HCWP Program Management Office (PMO) is presently headed by the hospital management officials shown in the box above with their corresponding functions.

The current organization is lean and lacks the needed administrative support. Since an office space was not available, the PMO alternately utilized the Director's office of Dr. Flores at E. Rodriguez Memorial Hospital, and a room assigned to Dr. San Pedro at DOH-HOMS.

A.1 Technical Service Group (TSG)

The TSG is made up of 55 members grouped into 21 teams of two to three members each, corresponding to the 21 program components. The members are made up of representatives from the Central Office public health services and their respective counterparts from the retained hospitals. The 21 teams correspond to 21 selected ongoing and prospective P/P/PHC programs in hospitals.

The 21 ongoing/prospective programs are the following:

1. Mother and Baby Friendly Hospital Initiative
2. Anti-Smoking and Preventive Cardiology
3. Family Planning
4. Control of Diarrheal Dis ease (CDD)
5. Control of Acute Respiratory Infections (CARI)
6. Maternal Care and Under 5 Clinics
7. Preventive Dentistry
8. Nutrition
9. Blindness Prevention Program
10. AIDS Prevention, Education, and Care
11. Preventive Nephrology
12. Cancer Prevention
13. Diabetes Control
14. Tuberculosis Control
15. Occupational Health/ Disability Prevention
16. STOP D.E.A.T.H.
17. Voluntary Blood Donation
18. Promotive/Preventive Mental Health
19. Environmental Health/ Hospital Waste Manage ment
20. Preventive Hospital Main tenance
21. Radiation Protection

In view of overlapping concerns, identical target groupings, shared preventive and promotive activities, diseases with related pathophysiologies, these programs were clustered into five, with the exception of health education which is carried out across all the programs. These various clusters are as follows:

I. Maternal and Child Health Cluster

Mother and Baby Friendly Hospital Initiative
Maternal Care and Under Five Clinics,
CDD & CARI
Family Planning
Preventive Dentistry
Nutrition
Cancer Prevention

II. Lifestyle Diseases Cluster

Preventive Nephrology
Anti-Smoking and Preventive Cardiology
Diabetes Control
Cancer Prevention
Blindness Prevention

III. Environmental Health Cluster

Environmental Health/ Hospital Waste Manage ment
Preventive Maintenance
Radiation Protection

IV. Infectious Diseases Cluster

Sexually Transmitted Disease/AIDS
Tuberculosis Control

V. Disasters, Traumas, and Emergencies Cluster

Mental Health
STOP D.E.A.T.H.
Occupational Health/ Disability/Accident Prevention
Voluntary Blood Donation

Single Program: Health Education

Learning from the Mother and Baby Friendly Hospitals initiative, cluster meetings were held to map out ten (10) steps to successful program implementation. On the other hand, key result areas (KRAs), defined as "areas where results should be delivered, excelled in or performed very well in order for the goals to be attained." were identified, initially on a per program basis prior to consolidation into cluster KRAs.

A.2 Hospital Action Group (HAG)

The initial appointment of twelve (12) hospital directors to the HAG was reconstituted during a national conference to include all hospital directors. The agreement was for HAG to be divided into geographic groupings with the following elected coordinators:

Metro Manila:
Dr. Romeo Cruz
Luzon Group:
Dr. Benjamin Morales
Visayas Group:
Dr. Quintin Derikito
Mindanao Group:
Dr. Gerardo Cunanan

While the HAG shall initially implement programs and activities of the HCWP, it will eventually evolve into a national network of DOH hospitals.

A.3 PPP Committees

Each retained hospital organized its PPP Committee to consist of the following: Chief of Hospital, Chief of Clinics, Training Officer, Chief Nurse, Chairpersons of Departments, Program Coordinators, Administrative Officer, Heads of Administrative units, representative of the Regional Health Field Office.

A.4 Program-Based Consortia

Of the 21 programs under the umbrella of the HWCP, the following eleven (11) programs have already established their respective program consortium and developed the hospital-based program components:

1 Diabetes Prevention and Control
2 Mental Health Program
3. Health Education and Promotion Program
4. National Cardiovascular Diseases Control Program
5. National Tuberculosis Program
6. Preventive Dentistry Program
7. STD-AIDS Program
8. Maternal and Child Health Program
9. Nutrition Program
10. Hospital Preventive Maintenance Program
11. Environmental Health/ Hospital Waste Management Program

Among the above consortia, a Diabetes Consortium which existed prior to the setting up of the HCWP among government hospitals in Metro Manila scored as the core in the establishment of a national Diabetes Consortium. In fact, it served as the model. On November 20, 1994, the HCWP spearheaded the holding of the first National Diabetes Congress held at the Mandaluyong Sports Center. Diabetics, their families, friends, support groups, non-government organizations, performing artists, and national and local government officials attended the affair.

With the formation of a nationwide organization, a line-up of major activities was subsequently drawn up.

B. MAJOR EVENTS

B.1 National Consultative Workshop

A **National Conference on Hospitals as Centers of Wellness** with the theme, *"Ospital Pinoy-Style: Sentro ng Kalusugan"* was held on 14 March 1994 in Imus, Cavite with 500 DOH officials and personnel in attendance. It was reportedly the first DOH conference which brought together hospital directors, chiefs of clinics, training officers, selected department chairpersons, program coordinators, with the service chiefs of the DOH central office, and directors of regional field health offices. A highlight was an exhibit featuring the various P/P/PHC programs and activities in retained hospitals,

The program conceptual framework was presented in a conference paper. In keeping with the theme, a distinguished anthropologist and an architect were invited to speak on "indigenous concepts of space and healing" vis-a-vis western concepts adopted in Filipino hospitals. The speakers called for a reorientation of hospital care which takes into consideration Filipino cultural patterns. In his speech, Secretary Juan M. Flavier recommended the tapping of watchers accompanying patients in the maintenance of cleanliness and in caring for the patient.

Satellite workshops were simultaneously held in the afternoon for the purpose of organizing 21 program-based consortia. The members of the Technical Service Group took charge of facilitating the identification of roles and functions, structures, election of officers and establishment of a coordination/communication system. A consortium action plan was also drawn up. The workshop was preparatory to the national launching of the HCWP in May 1994.

B.2 National Launching

All DOH retained hospitals simultaneously launched the **Hospitals as Centers of Wellness**

Program on May 16, 1994. There were four major launching areas, namely: Davao Regional Hospital in Tagum Davao del Norte; Vicente Soto Memorial Medical Center in Cebu City, Jose Reyes Memorial Medical Center in Manila, and Baguio General & Medical Center in Baguio City. Health Secretary Juan Flavier attended the launching at Davao, while DOH central and regional officials were dispersed to the 45 retained hospitals during the week-long celebration.

The DOH hospitals exercised initiative and creativity in staging various health activities and cultural shows to mark the national launching. Examples of these were:

o Cultural Show, Santacruzan, & a Variety Show graced by Singer Gary Valenciano at the Rizal Medical Center;

o "Breastfeeding Hotline"/TV guestings at V.Soto Medical Center;

o Cooking Demonstration "7 Malunggay Recipes" at Ilocos Regional Hospital;

o Cultural Show and Dance Contest at J. Reyes Medical Center;

o Solarium at Baguio General & Medical Center;

o Ilocano-Style fiesta at Mariano Marcos Memorial Medical Center;

o "Kontra Taba, Kontra Kaba" graced by Senator Nikki Coseteng at Quirino Memorial Medical Center

DOH officials, together with the program manager, appeared on television and radio shows to disseminate information about the program and invited the general public to visit the nearest DOH hospital for exhibits, lectures, health fairs, and medical check ups.

B.3 Year-end HCWP Conference

A two-day conference was held in Cagayan de Oro on November 15 & 16, 1994 with chiefs-of-hospitals of 45 retained hospitals in attendance. Program Manager Dr. Ruben Flores, presented the HCWP 1994 annual report and a five-year development plan. Among activities he announced for 1995 was the holding the **First National Wellness Awards** for innovative P/P/PHC programs in retained hospitals. He also presented a proposed program-wide monitoring and evaluation scheme for the deliberation of participants. Several directors forwarded their recommendations and suggestions for revision.

On the same day, Deputy Program Manager Dr. Victor de la Cruz formally organized the HAG in accordance with a structure unanimously agreed upon by the participants. Thus, in lieu of a committee composed of hospital directors, the body opted to set up a national network of DOH hospitals. With the estalishment of the network and the identification of major programmatic activities, a social preparation matrix was laid out next.

C. SOCIAL PREPARATION

C.1 Rationale

The baseline and pilot testing results have shown how well and intricately entrenched hospitals were in a purely disease-oriented medical tradition. The palpable resistance against P/P/PHC in hospitals - generally held as "outside" the purview of tertiary care centers - is further aggravated by a staff demoralized by organizational problems and bureaucratic constraints.

In view of the results, the social preparation of hospitals as organizations was considered crucial in establishing a clear and shared understanding of program concepts, principles, and strategies prior to action planning and implementation. Such an approach markedly deviates from the usual bureaucratic route

where program implementation solely hinges on departmental issuances, and compliance is assured for the duration of any given DOH leadership. With changes in administration, however, experience has shown that genuine and sustained reforms may not be possible.

C.2 Content

The social preparation of hospitals for HCWP consisted of welding together a series of training programs and action plans into a comprehensive two-day workshop made up of the following modules:

1. **Self-Awareness Module** (body awareness, affective release, cognitive styles);

2. **Organizational Review Module** (strengths, weaknesses, opportunities, threats)

3. **DOH Vision/Mission/Strategies Module**(state of health in the country)

4. **Hospitals as Centers of Wellness Module** (concepts, principles, strategies)

5. **Action Planning**

C.3 Participants

Approximately 1,500 employees attended the workshop, majority of them comprising the PPP Committees of DOH hospitals. The workshop was conducted in 44 retained hospitals from March to October 1994. Each of the workshops was attended by about 50 participants, including non-PPP members who requested participation.

C.4 Approach/Methodology

The self-awareness module made use of core energy, relaxation and creative visualization exercises to psychologically prepare participants for the succeeding modules. The session gave participants the opportunity to project insights about their beliefs, value systems and future plans. They were encouraged to symbolize their "experiences" through drawings. The facilitator interpreted their creative outputs.

The organizational review sought to assess the capability of each hospital in terms of staffing, skills level, equipment, and the supplies necessary for the enactment of action plans. The module also served as a diagnostic tool in determining the institutional readiness of hospital management and staff to innovate programs which radically depart from their curative orientation.

Non-verbal experiential team building exercises were done immediately prior to the organizational review session. Regarded as "energizers" since they resembled child's play, participants discovered that the movement and sound exercises, in effect, served as diagnostic tools in identifying organizational snags. Individual participants were then asked to indicate on a survey form what they perceive as the hospitals' strengths, weaknesses, opportunities and threats.

Upon completing the forms, participants were divided into the medical service, nursing service, and administrative service to discuss their responses. The ensuing plenary session was capped by a dialogue between management and the various services.

The next module on the DOH vision and mission, on the other hand, was presented against the backdrop of emerging diseases to highlight the need for a synergistic joint response on the part of hospitals and public health services. A brief historical account of how PHC evolved within the context of societal systems was included in order to highlight the crucial role hospitals play in disease prevention and health promotion.

The presentation of HCWP concepts, principles, and strategies inspired a philosophical discussion on the need to unify perceived polarities - as a first

step to "humanize and spiritualize" institutions which are mechanistic in orientation. At the close of the workshop, participants were encouraged to be at the forefront of change; that is, as witnesses to the daily reenactment of the human drama of life and death, they are in the best position to assume the role of key actors in the transformation of the so-called **Palaces of Disease** into **Centers of Wellness.**

C.5 Outcome: Self-Awareness Module

The self-awareness module stressed the need for personnel programs geared at physical and psychosocial development. Majority of the respondents, numbering 1,278 (85% of 1,500 participants) complained about feeling "tense, overworked, demoralized and burnt-out, resulting in work performance and outputs which leave much of their intellectual and creating potential to fallow.

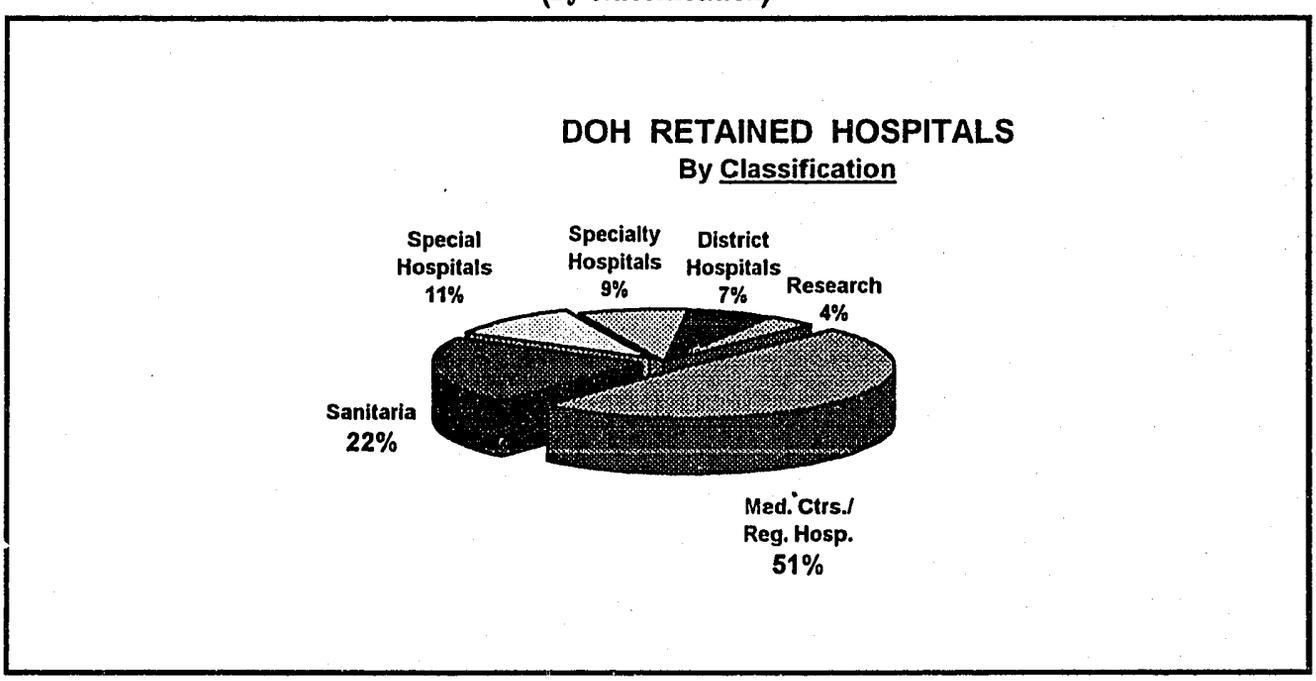
These manifestations were particularly marked among those aged 30 years and above. Older employees tended to be ambivalent towards retirement. While they looked forward to a "financial harvest" and a "time of their own", retireables seemed reluctant to reflect on their years of service in the hospital. On the other hand, personnel below 30 years of age, particularly nurses, regarded their government stint as a training ground for gaining work experience required by employers of other countries.

C.6 Outcome: Org'l. Review Module

The Organizational Review presented outcomes which are presented in graphic detail in Figures 1 - 8. Responses revolved around the following aspects of the retained hospitals' organizational life: hospital staff, facilities/equipment/resources, service, management/policies/sys-

HCWP ORGANIZATIONAL REVIEW OUTCOME

Figure 1
DOH RETAINED HOSPITALS
(By Classification)



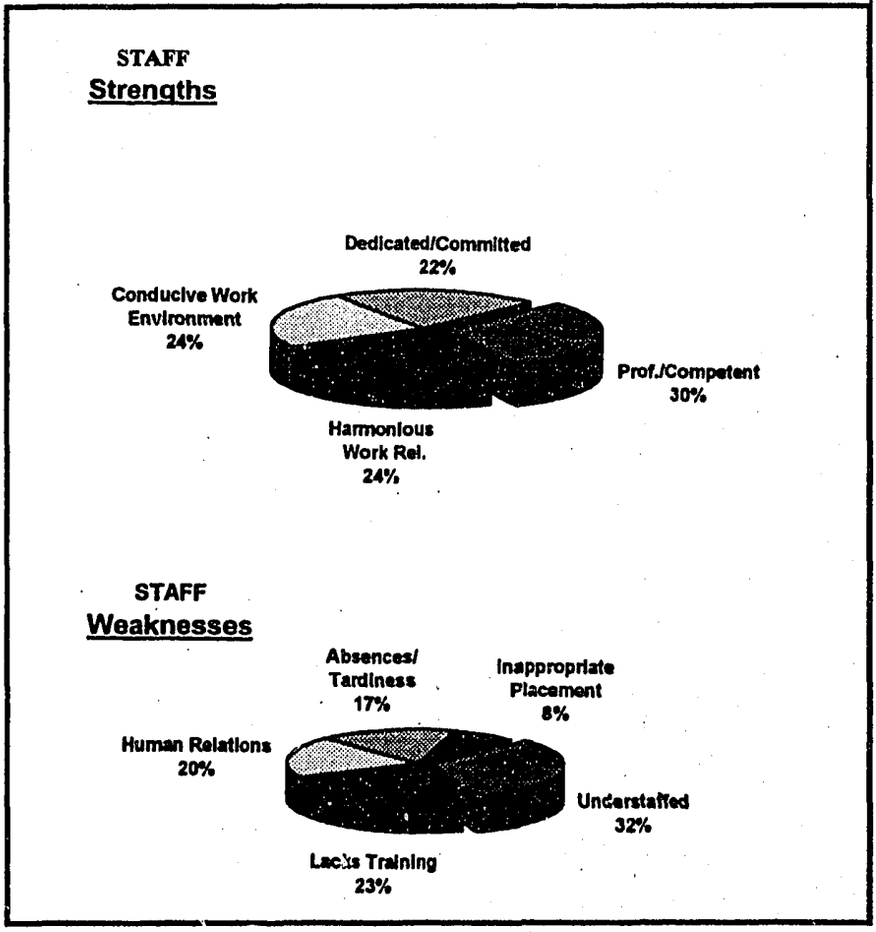
The factors behind their weaknesses, strengths, opportunities and threats are shown in percentages by the charts below. Figure 1 presents the DOH retained hospitals by classification:

C.6.1 Hospital Staff

A unanimous perception of hospital staff competence and professionalism surfaced in the 44 hospitals covered. Thirty-two (32) of the hospitals regularly commended their staff for dedication and willingness to serve "beyond the call of duty." Harmonious work relations were noted in 35 hospitals. This feedback, however, referred to small groups within separate work units. Twenty-six (26) hospitals identified "power struggles" and "internal politics" to be among their problems.

Forty-one (41) hospitals complained of understaffing and lack of manpower. Twenty-two (22) hospitals attributed the problem to absences/tardiness. Eighteen (18) hospitals claimed that manpower lack is the result of the fast turnover of staff while eleven (11) hospitals blamed this on the Attrition Law. Of the service groups, the nursing service was the most adversely affected.

Figure 2
STAFF STRENGTHS & WEAKNESSES



C.6.2 Facilities, Equipment & Resources

Conflicting results were noted when nineteen (19) out of twenty-five (25) hospitals reported "adequate facilities" as well as "lack of facilities." The contradictory feedback, however, merely referred to the rapid deterioration of existing facilities due to the lack of preventive maintenance programs.

While all hospitals cited the availability of supplies and drugs, they lamented the delayed procurement of these items due to the budgetary policies of the Department of Budget and Management (DBM). Hospital administrators felt caught between ensuring continued operations on one hand, and being hampered by government regulations, bureaucratic red tape, and lack of central office support on the other. According to them, the most difficult period in the operating year is the first quarter, when only half a month's (1/2) budget is released.

Other problems pertained to the lack of communication fa-

Figure 3
FACILITIES STRENGTHS & WEAKNESSES

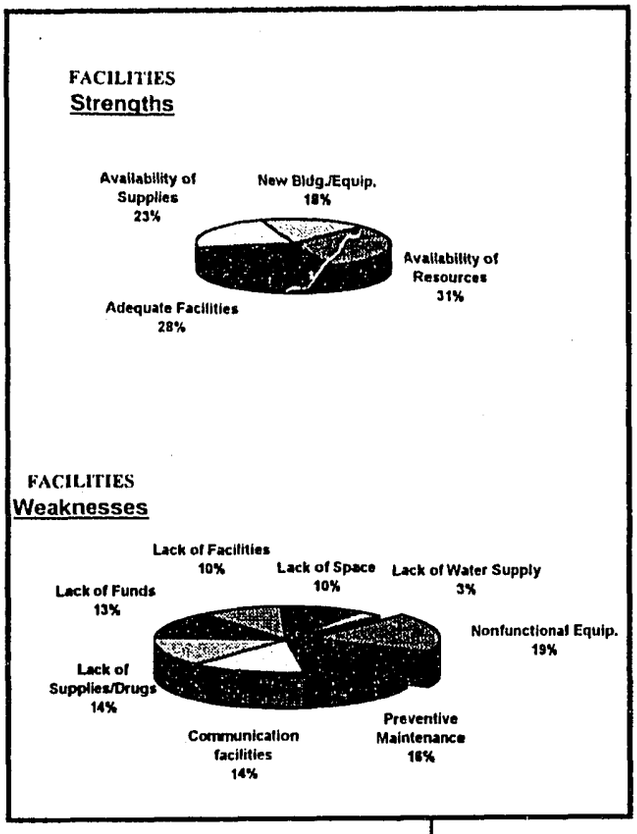
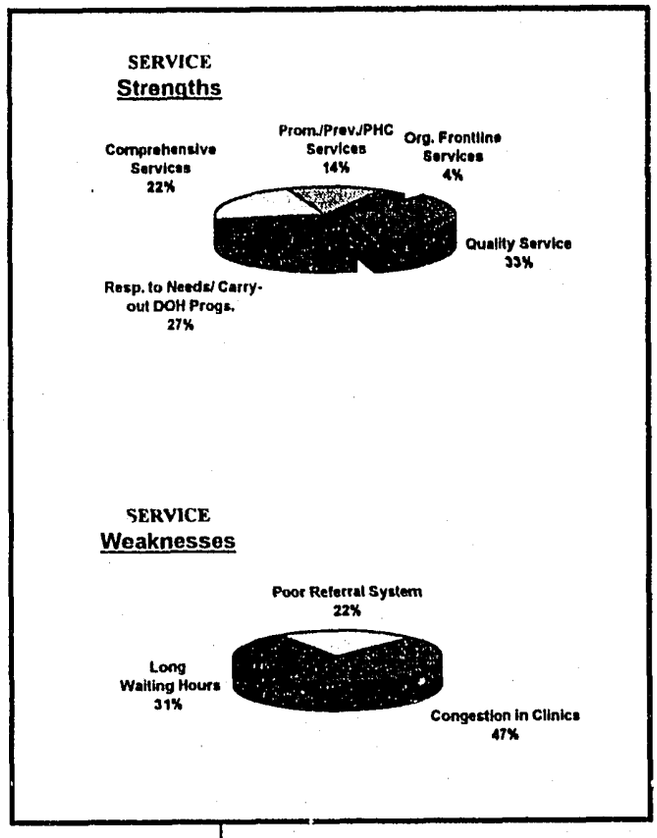


Figure 4
SERVICE STRENGTHS & WEAKNESSES



cilities (26 hospitals), lack of space (18 hospitals), and lack of water supply (6 hospitals). Twenty-three (23) hospitals cited irregular release of funds due to the budgetary cycle. The outcomes of the facililties review are shown in Figure 3.

C.6.3 Service

While thirty (30) hospitals said that the provision of quality medical service is a strength, they called attention to the following weaknesses: poor referral system, overcrowding, long waiting hours, and delay in admission and billing clearances. On the other hand, twenty-six (26) hospitals indicated satisfaction with their implementation of DOH programs; sixteen (16) of them proudly zeroing in on the success of P/P/PHC programs. Ten (10) hospitals noted the marked improvement of their frontline services.

C.6.4 Management Policies and Systems

Management support rated high among thirty (30) hospitals, twenty-four (24) of which commended their respective chiefs for outstanding leadership. However, management styles in fourteen (14) hospitals were generally perceived to be autocratic and highly centralized. Participatory management, found in nine (9) hospitals, was limited to the planning of activities.

While twenty-one (21) hospitals listed "established policies and operations" as an area of strength, participants complained of the non-implementation or inconsistent application of these policies. In thirteen (13) hospitals, low staff morale was attributed to the lack of reward and recognition system.

In thirty-two (32) hospitals, participants reported that the top-down flow of internal communication was poor, and feedback mechanisms were unavailable. This deficiency was viewed as a cause of inefficiency, organizational snags and staff relation problems.

All forty-four (44) hospitals expressed the need to review policies and streamline procedures owing to the prevalence of bureaucratic red tape, overlapping functions, and non-implementation of personnel policies.

C.6.5 Research and Training

Research projects were considered areas of strengths in nine (9) hospitals while training and continuing medical education were similarly regarded in twenty (20) hospitals. Meanwhile, eight (8) hospitals bewailed the lack of research activities while fourteen (14) hospitals found the need for more personnel training. In twenty six (26) institutions, the lack of training opportunities for administrtive staff was cited. Majority felt that opportunities for offshore training and educational trips should be more equitably distributed among central and peripheral DOH units.

C.6.6 Public Relations/ Networking

Twenty-four (24) hospitals enjoyed the support of local organizations, while eleven (11) hospitals, led by specialty institutions, reported linkages with international organizations. The four (4) specialty hospitals further expressed the need to strengthen/enhance their public

Figure 5
MANAGEMENT/POLICIES/SYSTEMS STRENGTHS & WEAKNESSES

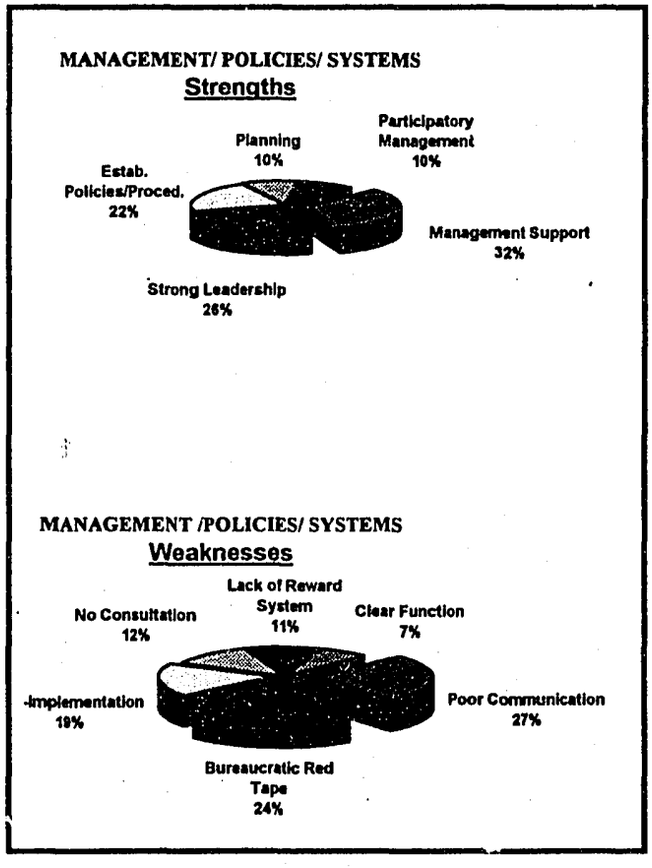


Figure 6
RESEARCH & TRAINING STRENGTHS & WEAKNESSES

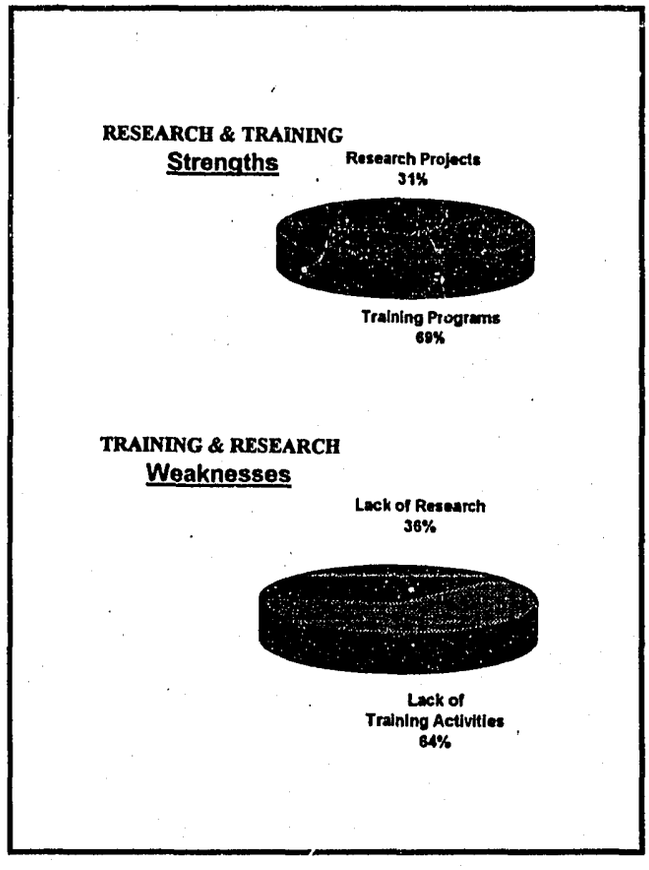


Figure 7
PUBLIC RELATIONS STRENGTHS & WEAKNESSES

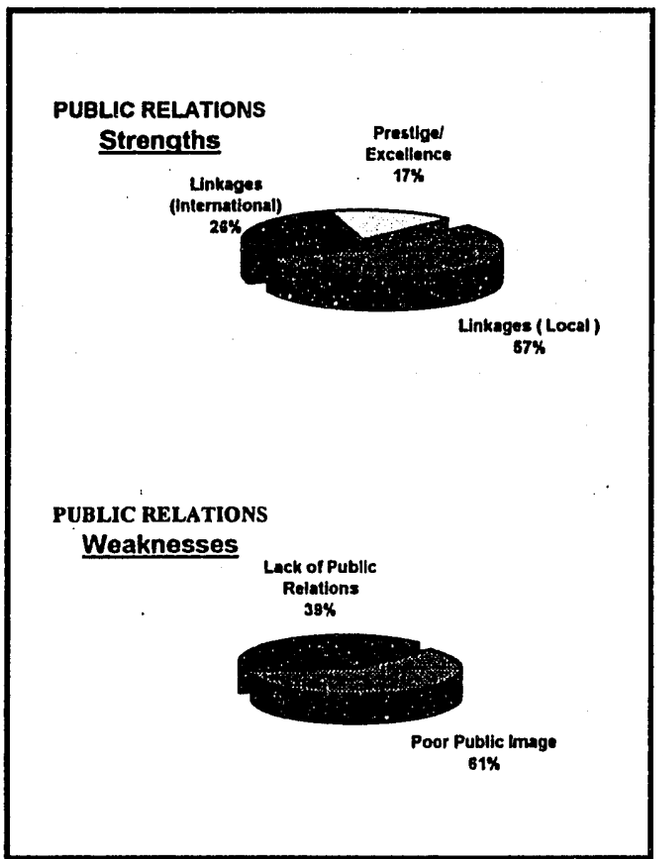
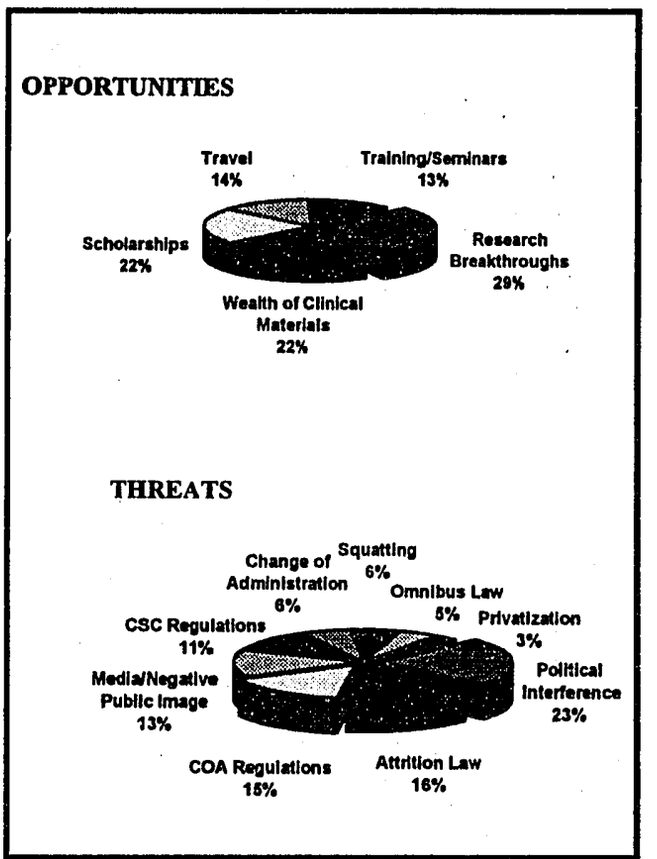


Figure 8
HOSPITAL OPPORTUNITIES & THREATS



information programs in order to project their institutions nationwide. Medical centers and regional hospitals, on the other hand, admitted having been affected by bad media publicity which contributed to their poor public image. Unlike specialty hospitals, these hospitals - faced by more pressing organizational problems - failed to give adequate importance to PR and IEC campaigns.

C.6.7 Opportunities

Training activities, seminar-workshops (39 hospitals) and scholarships abroad (9 hospitals) were among the opportunities enumerated. The wealth of available clinical materials was perceived to be a source of learning opportunities as well.

C.6.8 Threats

Political interference in the referral of non-indigents, the preferential treatment insisted by these recommendees, the writing off of hospitalization costs, the hiring of personnel and selection of applicants to residency training topped the list of threats in 39 hospitals. Other perceived threats were the following: bad media publicity, brain drain, Attrition Law, COA/CSC regulations, and privatization of government hospitals.

The eight (8) sanitaria surveyed cited the Omnibus Law which dealt with their conversion from institutions undertaking leprosy control into health facilities that addressed a diversity of other health needs. In their respective locales, the sanitaria were confronted by the resistance put up by cured Hansenites who

refused to be discharged. Rampant squatting on sanitaria grounds has also been reported.

D. Action Planning

Thirty seven (37) hospitals submitted action plans for HCWP. The remaining eight (8) hospitals which did not have action plans included four specialty hospitals, three sanitaria, and one special hospital.

The three sanitaria, consisting of Eversely Childs, J. Rodriguez Memorial Hospital and Cotabato Sanitarium temporarily begged off from action planning in view of their pending conversion into general hospitals. The National Center for Mental Health, for its part, was at the time being reorganized.

The action plans varied in approach: Eight (8) hospitals opted to be program-specific, fifteen (15) employed a hospital-wide approach, and ten (10) hospitals combined both. Program-specific hospitals subsumed all activities under vertical programs; a hospital wide approach, on the other hand, referred to activities stated in general terms involving two or more departments or services of the hospital. The hospitals which have formulated HCWP action plans under the different approaches are shown in Chart 4.

Chart 4
HCWP APPROACHES IN DOH RETAINED HOSPITALS

Program-Specific*	Hospital-Wide*	Program-Specific & Hospital-Wide*
Rizal Medical Center	Tondo Medical Center	E. Rodriguez Memorial Hospital
East Avenue Medical Center	J. Reyes Memorial Medical Center	National Children's Hospital
M. Marcos Memorial Medical Center	Baguio General Hospital and Medical Center	Quirino Medical Center
V. Sotto Memorial Medical Center	P. Garcia Research and Medical Center	Research Institute for Tropical Medicine
Davao Medical Center	Ilocos Regional Hospital	Valenzuela District Hospital
J. Lingad Memorial Hospital	Cagayan Valley Regional Hospital	Celestino Gallares Memorial Hospital
Cotabato Regional Hospital	Northern Mindanao Training and Regional Hospital	Eastern Visayas Regional Medical Center
Jose Fabella Memorial Hospital	Zamboanga City Medical Center	Western Visayas Medical Center
Davao Regional Hospital	Sulu Sanitarium	Western Visayas Sanitarium
Bicol Regional Hospital	Bicol Sanitarium	Culion Sanitarium
Corazon Locsin Memorial Regional Hospital	Las Pinas District Hospital	Cotabato Sanitarium
	Schistosomiasis Hospital	
	San Lazaro Hospital	
	Philippine Orthopedic Hospital	

** Several hospitals submitted a list and schedule of programs and activities only.*

D.1 Program-Specific Action Plans

Among the program-specific action plans, Jose Fabella Memorial Hospital stood out for its lactation brigades. While Rizal Medical Center had numerous programs listed in each department, its well established Adopt-A-Barangay project was not included. However, the lessons gained from these PHC projects which began in 1981 may serve as valuable inputs to hospital-wide orientation sessions for employees. Rizal Medical Center emphasized that it had plans to fortify linkages with civic organizations, among them *"Sinag"*, a counselling program for cancer patients.

Up and coming projects, on the other hand, included the following: Couples for Child (a street children project) at Mariano Marcos Memorial Medical Center and a Watchers' Kitchen at V. Sotto Memorial Medical Center. Most of the items listed in the action plan of Cotabato Regional Hospital were aimed at rendering screening and early detection/treatment services in every department. These activities fall under secondary prevention.

D.2 Hospital-Wide Action Plans

Hospital-wide action plans included personnel welfare programs at Tondo Medical Center, Baguio General Hospital, Zamboanga Medical Center, and Sulu Sanitarium. These included physical fitness programs for personnel. Tondo Medical Center employed a comprehensive organization development strategy consisting of a series of interaction and dialogue across work units to facilitate employee commitment to hospital programs and services, including the wellness program.

Some institutions intended to organize hospital-based support groups. In contrast to the Tondo Medical Center and the P.J. Garcia Research & Medical Center, the Schistosomiasis Hospital focused on the establishment of Schisto Clubs among former patients in endemic areas to help in health education and disease surveillance activities. Ilocos Regional Hospital and Sulu Sanitarium led hospitals planning to gain greater public support through the strengthening of organizational linkages.

D.3 Combined Program- Specific & Hospital-Wide Action Plans

Hospitals which used a two-pronged approach were E. Rodriguez Memorial Hospital which conducts activities involving various departments and administrative units, assisted by a diabetic support group (DOER), and various civic organizations such as *Sinag* and *Sukob*. Quirino Medical Center also had departmental activities and a Diabetes Club. Its plan to put up a bridging center as a venue for public health - hospital-private practitioner collaboration is an innovation worth waiting for. The National Children's Hospital is the only institution which holds income generating skills training for mothers.

The unique features of E. Rodriguez Hospital, Quirino Medical Center, and the National Children's Hospital are their personnel programs. E. Rodriguez Hospital will open an aerobics program for the staff upon the completion of its Wellness Building. The National Children's Hospital and Quirino Medical Center entitle their employees to regular medical check-ups. The former has even established an employee infirmary within its premises. Notwithstanding the approaches taken, several observations were noted.

E. Further Observations

Hospitals, it was noted, were found to have taken off with their respective P/P/PHC programs on their initiative, and exercised implementing options considered appropriate and effective. Points of observation covered the following:

1. Hospitals did not limit their implementation plans to Phase I programs and activities. Action plans indicated that these hospitals have been

carrying out DOH programs listed under Phase II and Phase II even prior to the HCWP;

2. In addition to Phase I-III programs, hospitals identified the P/P/PHC activities pertinent to their departments; majority of these however, were geared towards the enhancement of screening, early detection, and treatment of certain diseases; furthermore, health education was being conducted in wards, the outpatient department, and among watchers.

3. For the initial year of the HCWP, most hospitals opted to confine P/P/PHC activities within their premises; outreach programs were limited to medical missions and the setting up of linkages; only a handful of hospitals intended to sustain community development projects outside hospital grounds.

4. Program-specific activities consisted of in-house technical capability building programs common among medical staff, and other training programs for non-medical staff, patients, and their families.

5. Health advocacy plans were nil, and no efforts were made to improve media relations or the hospitals' public image.

6. Majority of the plans left out personnel welfare programs; a number of implementation plans covered physical fitness and annual check ups for employees; only two hospitals devised a total human resource and organization development approach in providing care for caregivers.

7. Logistical support ranged from P100,000 to P2 M per hospital. Most of the items required by individual programs included audio-visual equipment and the reproduction of IEC materials; others included drugs, supplies, and equipment for screening and laboratory examination. Only one hospital planned to put up a Wellness Building.

IV.

CONCLUSION

The overwhelming response of retained hospitals to the **Hospitals as Centers of Wellness Program,** as manifested by their initiative to disregard the phasing of P/P/PHC in lieu of carrying out as many programs as possible, stemmed from an inter-agency motivation to "DOH it." The following are the major conclusions culled from the early experiences of the program.

1. On hospitals' positive response to HCWP

There is basis for this commitment. For the strength of retained hospitals lies in the technical competence of their personnel. It is, therefore, understandable why majority of these institutions devised activities on a per department basis, which involved secondary disease prevention: screening, early detection, and treatment. In effect, these hospitals took off from a position of strength, and in a manner of speaking, the **Hospitals as Centers of Wellness Program** indeed began "where the hospitals were." An approach that is consonant with the people-empowering strategies of PHC augurs well for a program which, at first blush, was met by seemingly insurmountable resistance.

2. On hospitals' resistance to HCWP

The initial resistance to HCWP evident during the baseline research and pilot testing is not necessarily country-based. Hospitals worldwide were founded on a long tradition of curative care, their doctors singularly plodding along well defined specialty lines within the confines of medical institutions which were literally **"palaces of disease"** as aptly referred to. In contrast, public health physicians immerse themselves in community work and leap roughshod across multisectoral boundaries in an effort to contain the spread of disease - **"prevention-oriented"** as they were called. Like the proverbial east and west, the medical tradition forged along separate paths, with each camp believing that "never the twain shall meet." Changing epidemiological landscapes, however, disrupted the medical playing field. The emergence of lifestyle diseases threatening the greater population redirected hospitals and public health services towards synergistic action. Indeed, the time for unity has arrived.

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In order to counter the identified blocks, a social preparation workshop was designed to facilitate the necessary professional and organizational self-diagnosis and serve as a clearing ground for the seeds of wellness to be planted. The self-awareness module made participants realize the need to unify fragmentary modes of "structuring" the world, i.e. to view polarities not at odds with each other but as mere complements like two sides of a coin, discussed within the medical traditions of prevention versus cure. Participants realized that, despite their technical knowhow, their vast creative potentials have long lain fallow. In order to find more meaning in their lives, they had to free themselves from the soporific grip of complacency and dualistic thinking.

The organizational review, on the other hand, enabled hospitals to dissect their organization by bringing their problems to the "examination table." By clarifying issues, resolving conflicts, jointly seeking solutions, and forging compromises, participants underwent the "necessary pain" of facing the truth and learning from it.

3. On the implications of the organizational review outcome of HCWP

The organizational review outcome underscored the value of human resource both in fostering a hospital milieu which promotes healing and wellness as well as provides quality curative care. The results of the organizational review require a serious follow-through among retained hospitals to look into the areas of concern outlined in the preceding section, and ensure that follow-up sessions are collectively carried out and participated in by key officers.

The hospitals' strength, as earlier mentioned, lay in technical competence, but low morale and mediocre career goals seemed to prevail in most institutional settings. Even among the country's prime medical institutions, i.e. the four specialty hospitals which were generally well managed and manned by highly competent medical staff, the same complacent work attitudes seem to permeate through the rank and file. Hospital administrators, in general, tended to gloss over employee dissatisfaction, low levels of productivity, and lack of quality consciousness among them. Employees in the lower brackets appear to have been neglected as far as training programs were concerned.

In most hospitals, decision-making was described as highly centralized, and only a handful were tapped to participate in planning; a dearth in monitoring and evaluation activities was also observed. While leaning towards autocratic approach may not necessarily be ineffective, the lack of adequate information dissemination across the organization usually resulted in operational lapses, wastage of resources, and gaps in human relations and communication. In certain medical centers and regional hospitals, communication breakdown was attributed to the lack of regular conferences. An expressed need to conduct team building sessions was noted in most of these hospitals, particularly among different internal services.

Manpower shortage was repeatedly mentioned. In some hospitals, however, the probiem of lack of manpower was offset by the tapping of hospital-based support groups and other volunteers who assumed a number of duties such as health education, records-keeping, upkeep of hospital grounds, networking, etc.

Another organizational weakness centered on the lack of facilities and equipment, and the inadequacy or non-availability of drugs and supplies. The solution to these problems obviously lay in policy review at the national level. Other organizational issues pertained to the adoption of personnel systems such as the following: flexitime for nonmedical staff, private practice of consultants, inclusion of the 24-hour duty as part of official time, annual physical check ups, work hazards especially in infectious areas, prorated hazard pay for adminstrative personnel, etc. Furthermore, while medical centers

and regional hospitals tended to brush aside bad media publicity as the least of their priorities, the matter must be reviewed since media plays a crucial role in health advocacy campaign.

4. Sustaining wellness among hospitals: the PRIORTECH Strategy

The HCWP Priortech Strategy shall be employed to ensure program sustainability. Since people empowerment undergirds Primary Health Care and Organization Development, both approaches shall be carried out vigorously at the same time. Thus, PHC shall focus on hospital based organizing anchored on people participation and self reliance, while OD shall foster a hospital "culture" that is conducive to healing and growth predicated upon the work values of excellence, service, and innovation.

In particular, the following activities are envisioned to promote program sustainability:

Activities under PRIORTECH strategy

1. People Participation and Self-Reliance

Hospital Based Organizing (HBO) shall be carried out for the purpose of establishing a national coalition for health to be known as the **Filipino Wellness Corps (FILWELL).** In achieving this goal, the following activities are lined up:

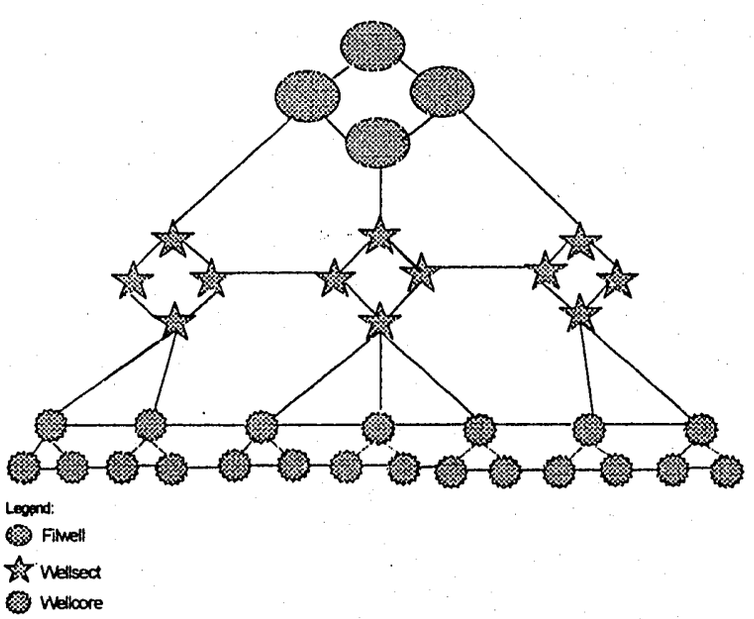
1.1.1 Organize personnel, patients, and their families into support groups;

1.1.2 Establish a Wellness Core Group **(WellCore)** (see Figure 9 below) among representatives of support groups; the WellCore shall be the central coordinating body to serve as conduit between the hospital and the communities that it serves; it shall update the hospital of changing needs and current events in the community as part of their disease surveillance activities, interrelatedly;

1.1.3 Each Well Core member, in turn, shall tap representatives of GO's, NGO's, civic organizations, volunteers and local government executives (case-to-case basis) to organize the Wellness Sectoral Groups **(WellSect);**

1.1.4 The DOH WellCores shall facilitate the formation of similarWellCores in other government facilities and private hospitals with the

Figure 9
PROPOSED HOSPITAL-BASED COALITION
THE FILIPINO WELLNESS CORE
("FILWELL")



end goal of organizing a national network of wellness organizations;

1.1.5 The different **WellSects** shall comprise the Filipino Wellness Core Groups **(FILWELL)**, the over-all citizens' arm engaged in disease prevention and health promotion; it shall forge alliances with all government agencies, NGO's, specialty societies, the private sector, etc., in the grand coalition for Health for all Filipinos in the advent of the 21st century.

1.2 Personnel Development Towards the Pursuit of Excellence and Service

1.2.1 Hospital Directors and the key officers of each hospital shall conceive a hospital vision in line with the over all vision of the DOH;

1.2.2 Following the findings of the organizational review, a survey on "employee perception of various aspects of the hospital" may be carried out, using a stratified random sampling to ensure full representation of work units;

1.2.3 The survey results shall determine organizational development interventions which may be carried out in order to instill in every employee a commitment to the hospital and DOH vision;

1.2.4 The survey findings shall also identify the necessary reforms in hospital operations and management; in policy review, and procedural reform; however, a consideration of the locality's culture may be examined vis-a-vis the internal "hospital culture" unravelled by the survey;

1.2.5 Recognition and awarding systems may be devised to reinforce organizational reforms and to encourage appropriate employee behavioral changes.

PHC focuses on hospital-based organizing anchored on people participation and self-reliance...

2. Mobilizing the Bureaucracy

The Program Management Office, in coordination with the Internal Planning Service, shall facilitate planning sessions in the various DOH central and regional field offices to develop comprehensive plans in support of HCWP implementation in retained hospitals. The DOH service units and program offices may likewise help mobilize non-DOH agencies and organizations which can provide assistance. The specific needs of different hospitals will provide the inputs to these plans.

The organizational review outcome has initially pointed to the following felt needs:

2.1 Specialty Hospitals:

2.1.1 Establishment of Public/Media Relations to project these institutions nationwide;

2.1.2 Preventive maintenance of deteriorating state-of-the-art equipment;

2.2 Special Hospitals/Medical Centers/Regional/District Hospitals:

2.2.1 Hospital-wide orientation on HCWP

with the end goal of transforming every personnel into a health advocate;

2.2.2 Orientation and organization of skills training along PHC principles and strategies;

2.2.3 Training in advocacy programs; preparation of IEC materials;

2.2.4 Policy and systems review; development of quality assurance programs;

2.2.5 Executive Management Programs/ Continuing Education including scholarships at the Asian Institute of Management (AIM) or any other institution of higher learning, to reinforce masteral degrees in hospital management;

2.2.6 Inclusion of administrative personnel in training programs and scholarships;

2.2.7 Psychosocial programs for personnel well-being such as recreational, artistic, & sports activities; establishment of a Wellness Foundation to benefit personnel and their dependents or strengthen employee cooperatives for income-generating projects; establishment of schistosomiasis control in other endemic parts of the country;

2.3 Schistosomiasis Hospital

2.4 Sanitaria:

2.4.1 Provision of logistical/administrative/ technical requirements in their transformation into general hospitals;

2.4.2 Legal assistance in handling rampant squatting in hospital grounds and in discharging former Hansenites residing within their premises; (Items 2.2.1 to 2.2.7 also apply to sanitaria)

V.

RECOMMENDATIONS

Based on the foregoing study results and programmatic discussion, the following courses of action are recommended:

1. There is a need to provide the HCWP Program Management Office (PMO) with manpower and administrative support; ideally, the HCWP shall be housed within the Hospital Operations and Management Service (HOMS), the office mandated to take charge of all hospitals under the DOH;

2. There is a need to involve various central office services and programs and regional health field offices in the provision of the necessary administrative and technical support to the HWCP;

3. The Technical Service Group shall function as internal consultants to DOH hospitals; it shall develop manuals on the different programs under its umbrella for hospital use; it shall provide inputs to PIHES for the publication of manuals for lay health advocates; the remaining ten (10) program consortia shall be strengthened; the TSG shall tap the assistance of professional groups and specialty societies in setting up national networks for the control of particular diseases;

4. The Hospital Action Group shall be activated to function as the Hospital National Network (HNN) for HCWP and other priority programs of the DOH;

5. There is need to carry out a hospital-wide orientation on HCWP where every employee shall identify his/her individual contribution to their hospital's transformation into a **Center of Wellness** using the 6 C's, 3 P's and 10 Steps to Becoming Centers of Wellness (see Chart 5, page 45) as guidelines;

6. The PPP Committee shall commence hospital-based organizing of the different support groups; organizing shall be done alongside health education programs tailored to the needs of these groups;

7. The Program Consortia shall establish a data bank

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on various diseases by initially pooling together hospital census and other relevant information; the data bank shall serve as basis for identifying priority activities, as well as the needed assistance from DOH offices, specialty societies, and other organizations;

8. There is a need to institute National Awards in order to sustain the gains of HCWP, and to project DOH hospitals as models for other hospitals to follow; awards may fall under the following categories:

8.1 Innovative P/P/PHC programs

8.2 Recognition of outstanding individual innovations/contributions or the Ten Outstanding Wellness Innovators (TOWN); and

8.3 Model Centers of Wellness;

9. There is a need to develop model **Centers of Wellness** and to lay the groundwork for the Program's replication among devolved and private hospitals; economic benefits and costs of hospital involvement in P/P/PHC shall be incorporated among the evaluation parameters of the HCWP.

As a developmental program, the HCWP shall sustain the advocacy for "Healthy Hospitals" among devolved and private hospitals which are not under the supervision of the DOH;

10. There is a need to draw up policies in support of the HCWP such as the following:

10.1 Hospital budget allocation to include P/P/PHC programs and activities;

10.2 Conversion of all hospitals in the country into **Centers of Wellness** through the legislation of the Hospitals as Centers of Wellness Act;

10.3 Inclusion of P/P/PHC in residency training programs accredited by specialty boards;

10.4 Mandate for DOH to review legislators' individual allocation to retained hospitals in order to preclude disruption of Program goals and gains;

10.5 Creation of a line item for Health Education and Promotion Officers (HEPOs) among hospitals;

10.6 Inclusion of P/P/PHC in school curricula through the Department of Education, Culture & Sports (DECS);

11. Alongside strengthening traditionally disease-based programs, hospitals should increasingly interface with their public health counterparts and the general public in the development of people-oriented programs such as women's health, health for migrant workers and other occupational groups, the youth and the elderly, etc. and integrate these into the mainstream of the total health care delivery system. These pooled efforts will result in the realization of **Hospitals as Center of Wellness** goals well into the next millenium.



Chart 5
10 STEPS TO BECOME A CENTER OF WELLNESS

1. Develop policies on converting the hospital into a **Center of Wellness.**
2. Implement a continuing hospital-wide orientation and values clarification.
3. Organize a hospital Preventive/Promotive/Primary Health Care (PPP) Committee to oversee and implement the program.
4. Train hospital personnel on Preventive/Promotive/Primary Health Care programs.
5. Promote excellence in hospital services and operations to ensure a competent and well-managed hospital.
6. Ensure people-friendly staff by promoting personnel welfare and job satisfaction.
7. Provide an environment conducive to healing through clean and green premises, opportunities for interaction, psychosocial and spiritual support.
8. Establish a well-equipped health education area for the regular conduct of hospital-wide health education activities.
9. Mobilize personnel, patients, their families and other volunteers into support groups.
10. Establish linkages with public health offices, other government/non-government organizations, volunteer groups for service complementation, resource mobilization and program support.

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